Table 2 Details of STIs diagnosed in men and women

	Male			Female		
	Jan–Sept 2001 (n = 6920)	Jan–Sept 2002 (n = 6659)		Jan–Sept 2001 (n = 4794)	Jan–Sept 2002 (n = 4690)	
	No (prevalence per 100 patient)		p Value using χ^2 test	No (prevalence per 100 patient)		p Value using χ^2 test
A1	37 (0.5)	53 (0.8)	0.061	0 (0.0)	3 (0.1)	0.121*
B1	262 (3.8)	190 (2.9)	0.002	41 (0.9)	35 (0.7)	0.552
C4a/C4c	244 (3.5)	179 (2.7)	0.005	187 (3.9)	199 (4.2)	0.399
C4h	683 (9.9)	479 (7.2)	<0.001	–	–	–
C10a	89 (1.3)	55 (0.8)	0.009	111 (2.3)	80 (1.7)	0.035
C11a	264 (3.8)	254 (3.8)	0.998	147 (3.1)	164 (3.5)	0.239
Total diagnosed with an STI at this episode	1579 (22.8)	1210 (18.2)	<0.001	486 (10.1)	481(10.3)	0.849

*p Value using χ^2 test with Yates's correction.
(A1) Primary diagnosis of syphilis; (B1) gonorrhoea; (C4a, C4c) uncomplicated chlamydia; (C4h) non-gonococcal urethritis; (C10a) first attack of genital herpes; (C11a) anogenital warts.

over this period did not change. We have shown however a dramatic change in the number of STI diagnoses made over these two periods.

Tables 1 and 2 highlight a significant fall in the total number of STI diagnoses for gonorrhoea (B1), uncomplicated chlamydia (C4a, C4c), non-gonococcal urethritis (C4h), and first attack of genital herpes (C10a) in our male patients. The only significant fall for women was seen in the diagnosis of a first attack of genital herpes. There was no significant change for both sexes in the diagnosis of anogenital warts (C11a) between the two systems. The rise in primary diagnosis of syphilis (A1) reflects the beginning of the current epidemic in London, boosted further by a proactive approach to diagnosis in our HIV positive population.[2]

This fall in acute STI diagnoses in men was approximately twice as marked for men who have sex with men (data not shown).

Our aim in planning the change to a primarily appointment based system was to improve patient experience, by reducing waiting times, and enhance access for symptomatic patients into reserved appointment slots. These data show evidence for an opposite effect which we believe has resulted from asymptomatic individuals requiring sexual health screening booking the majority of clinic appointments well ahead of their appointment, thereby reducing access at convenient times for symptomatic individuals who telephone.

To respond to this we have adjusted the ratio of prebooked versus emergency appointments and significantly amended our approach to triage of symptomatic patients, in an attempt to reverse these trends. Particular attention is now being given to our telephone booking protocol to facilitate symptomatic patients to achieve prompt, immediate appointments. We are publishing these findings to inform others who are implementing changes in clinic appointment schedules, designed to enhance access, to better tailor the booking and triage systems to achieve this goal. We will continue to audit our system to examine the effect of the revised system and to further examine why the change to our appointment system disproportionately affected those men who have sex with men.

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2 **Winston A**, Hawkins DA, Mandalia S, *et al.* Is increased surveillance for asymptomatic syphilis in an HIV outpatient department worthwhile? *Sex Transm Infect* 2003;**79**:257–9.

Prevalence of HSV-1/HSV-2 antibodies in HIV seropositive patients in Coventry, United Kingdom

The seroprevalence of herpes simplex virus (HSV) antibody among HIV patients within the United Kingdom is unknown. We therefore conducted a HSV seroprevalence study in HIV patients attending our genitourinary medicine clinic from January 2000 to December 2001. Our previous study[1] revealed an overall prevalence of HSV-1 (60%), HSV-2 (20%), and both HSV-1 and HSV-2 (12%) among male and female genitourinary medicine clinic attendees who were either HIV negative or whose HIV status was unknown.

Serum samples from 96 consecutive ethnically diverse HIV patients were collected during routine investigations, and tested for HSV type specific antibodies by monoclonal antibody blocking enzyme linked immunoassay.[2] Out of 96 patients, two HSV-1 and three HSV-2 antibody test results were equivocal in four individuals. These were excluded from the analysis and results are presented here for 92 patients.

There were 56 men and 36 women in the study: 46 (50%) were white, 43 (47%) black African, and three were from other ethnic groups. All the black Africans were heterosexuals and 71% of men were homosexuals. The median age was 35 years (range 21–80).

HSV-1 seroprevalence was 86% among men and 97% among women ($p = 0.14$). HSV-2 seroprevalence was 50% among men whereas it was 94% among women ($p = 0.0001$). There was no statistically significant difference between the seroprevalence of HSV-1 between white and black people. However, seroprevalence of HSV-2 and both serotypes was significantly higher among black than among white people.

This study shows very high seroprevalence of HSV-1 (90%), HSV-2 (67%), and both HSV-1 and HSV-2 (64%) among our HIV positive cohort in Coventry. The high prevalence of HSV-2 in women is possibly because most of them were black African and acquired HIV through sex. These findings may have important public health implications as the high rate of HSV-2 is therefore likely to act as a cofactor in HIV transmission.

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2 **Van Doornum GJJ**, Slomka MJ, Buimer M, *et al.* Comparison of a monoclonal antibody-blocking enzyme-linked immunoassay and a strip immunoblot assay for identifying type-specific herpes simplex type 2 serological responses. *Clini Diagn Lab Immunol* 2000;**7**(4):641–4.

BOOK REVIEW

Effective Sexual Health Interventions: Issues In Experimental Evaluation

Ed Judith M Stephenson, John Imrie, and Chris Bonell. Pp 232; £55. Oxford: Oxford University Press, 2003. ISBN 0-19-850849-2.

HIV spreads more every day and there are epidemics of other STIs in both the developed and developing world at least in part because the fear of HIV appears to be receding in the population. Our current strategies to contain these problems are meeting with limited success and treatment of people who are already infected, important though that is in controlling bacterial infections, is much less effective with continuing viral infections. There is an urgent need to develop and to test better

methods of helping people to reduce their risky sexual behaviour.

This book is excellent, brief, fairly comprehensive, and very readable. Its focus is designing studies on the effectiveness of sexual health interventions. If we are to get anywhere in improving behavioural interventions it is essential that what is done is carefully evaluated.

The first three chapters of the book are concerned with methodology, particularly whether randomised controlled (RCTs) trials are an appropriate method for evaluating interventions in this area. While this section of the book is well argued on all sides it doesn't really break any new ground. The strengths and weaknesses of RCTs in behaviour change are pretty much what they are in any other area of medicine. Methodologies don't exist as stand alone phenomena, whether an RCT or some other methodology is appropriate depends simply on what question one is seeking to answer.

The second section of the book covers models of behaviour change and the choice of design and outcome measures. It is clear that one of the main problems in intervening in sexual health is the poor quality of the available psychological models and our real lack of understanding about why people behave as they do. Without understanding why people behave as they do it is difficult to help them to change. It is interesting that models of health behaviour never seem to get discarded, even the ones that are known to be weak. There are particularly strong chapters on cluster randomisation, an approach which probably gives rise to more inappropriate statistics than any other and on complex behavioural measures. The latter should be required reading for anyone measuring any aspect of risky sexual behaviour simply because it highlights how weak many studies of sexual behaviour—and not just of behaviour change—are in this respect.

The book ends by looking at generalisability in its broadest sense. Generalisability is an area that tends to get overlooked. Even a highly successful behaviour change programme would be of no use in developing countries if it was labour intensive and dependent on highly skilled staff for its delivery.

I would recommend this book to anyone planning a trial or simply seeking to understand the existing literature. I would however caution that to make sense of it you will have to look at some of the available reviews of the behaviour change literature since the book assumes some knowledge, or willingness to acquire knowledge, of these.

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NOTICES

Australasian Sexual Health Conference 2004: Behind the Mask

This conference will be held at the Adelaide Convention Centre, South Australia, on 31 March to 3 April 2004. For further details please contact Dart Associates (tel +61 2 9418 9396/97; email dartconv@mpx.com.au; and website http://www.acshp.org.au).

8th European Society of Contraception Congress

The 8th European Society of Contraception Congress will be held from 23–26 June 2004 in Edinburgh, Scotland, UK. For further details please contact ESC Central Office, c/o Orga-Med Congress Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed.ann@pandora.be; and website: http://www.contraception-esc.com/edinburg.htm).

CORRECTIONS

In the October issue of *STI* table 2 of the paper by Zheng *et al* (Zheng HP, Cao WL, Wu XZ, Yang LG. Antimicrobial susceptibility of *Neisseria gonorrhoeae* strains isolated in Guangzhou, China, 1996–2001. *Sex Transm Infect* 2003;**79**:399–402) was published with incorrect column headings. Under the heading spectinomycin only ''S(%)'' and ''R(%)'' should appear and under ceftriaxone ''S(%)'', ''I(%)'', and ''R(%)'' should appear, in that order. Under ciprofloxacin ''S(%)'', ''I(%)'', and ''R(%)'' should appear. A corrected version of the table can be found on the website at http://sti.bmjjournals.com/cgi/content/full/79/5/399/DC1.

The authors of a letter in the December issue of STI (Dave SS, Johnson AM, Fenton KA, Mercer CH, Erens B, Wellings K. Male circumcision in Britain: findings from a national probability sample survey. *Sex Transm Infect* 2003;**79**:499–500) were listed in the wrong order. The correct author list should be as follows: Dave SS, Fenton KA, Mercer CH, Erens B, Wellings K, Johnson AM.

In the corresponding author's address of a letter published in the December issue (Bhatia R, Prabhakar S, Shedde D, *et al*. Coexistent cranial tuberculomas and tuberculosis of the cervix in a postmenopausal woman. *Sex Transm Infect* 2003;**79**:496–7) All India Institute of Medical Sciences was incorrectly printed as AU India Institute of Medical Sciences.